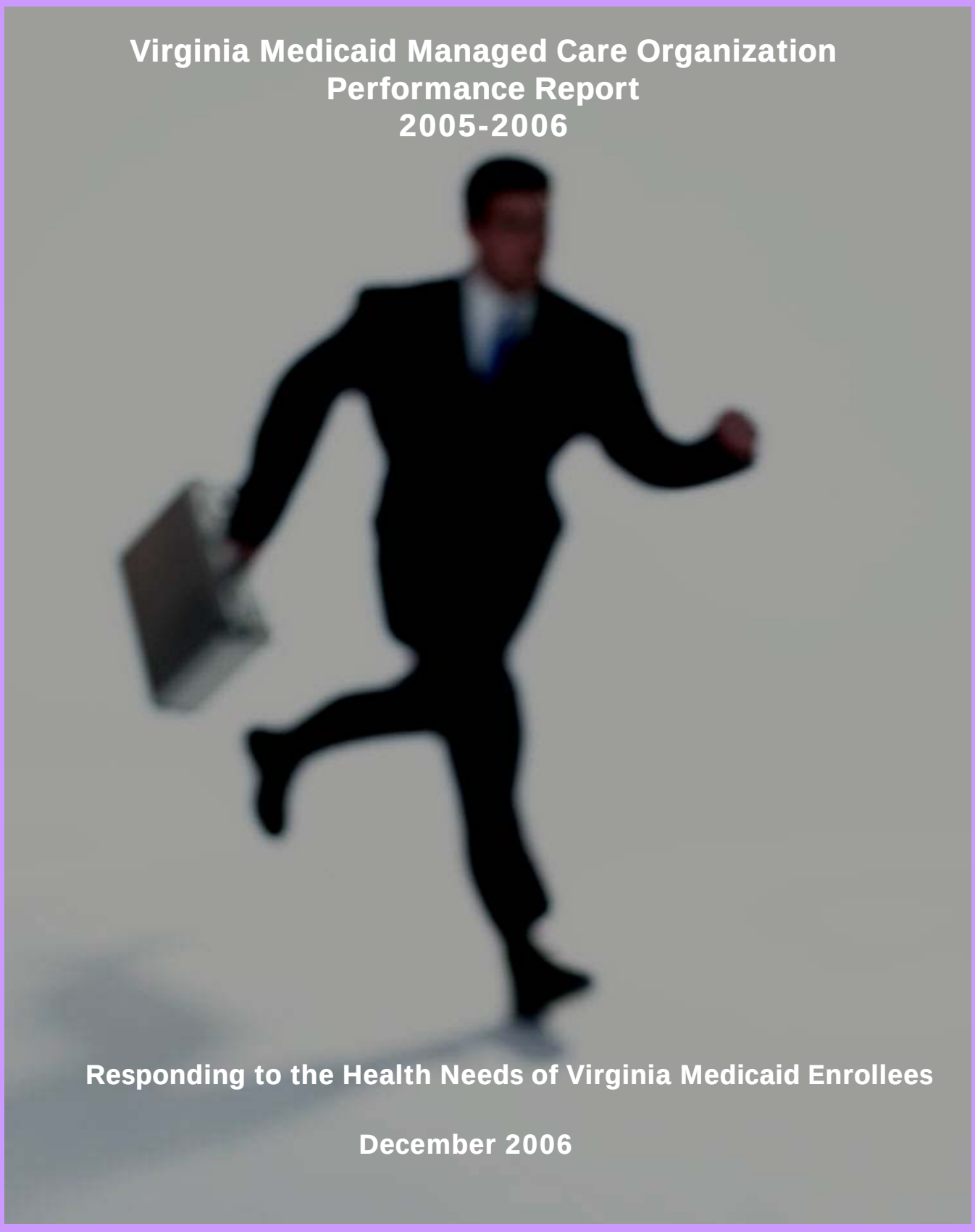
Virginia Medicaid Managed Care Organization Performance Report 2005-2006



Responding to the Health Needs of Virginia Medicaid Enrollees

December 2006

www.dmas.virginia.gov/mc-home

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Introduction: Responding to the Needs of the Commonwealth

This is the fifth installment in a series of annual managed care organization performance reports which summarizes program highlights during State Fiscal Year 2006 (July 1, 2005 through June 30, 2006).

The Virginia managed care organization program, Medallion II, is a significant part of the Medicaid/FAMIS program. Virginia works with five managed care organizations (MCO) to deliver services to its enrollees: AMERIGROUP Virginia, Anthem, Inc., Virginia Premier Health Plan, Optima Family Care, and CareNet/Southern Health Services. The Medallion II program represents $1.1 billion (25%) of Virginia's budget and more than half of the program's enrollees.

The following report details how the Department, with the collaboration of the Medicaid/FAMIS managed care health plans and other Medicaid programs (i.e., long-term care and fee-for-service disease management) have currently responded to the needs of our enrollees. In addition, this report highlights new initiatives that address emergent and future healthcare concerns.

Virginia Medicaid and Managed Care Program

The Virginia Department of Medical Assistance Services (DMAS), the agency that administers the Virginia Medicaid program, primarily serves the low income population of the Commonwealth through two delivery programs based on the population and the locality of enrollees:

1) Fee-for-Service (FFS)

- **Title XIX** (Standard Medicaid program)

- **MEDALLION**, a Primary Care Case Management (PCCM) program utilizing contracted primary care providers in certain localities

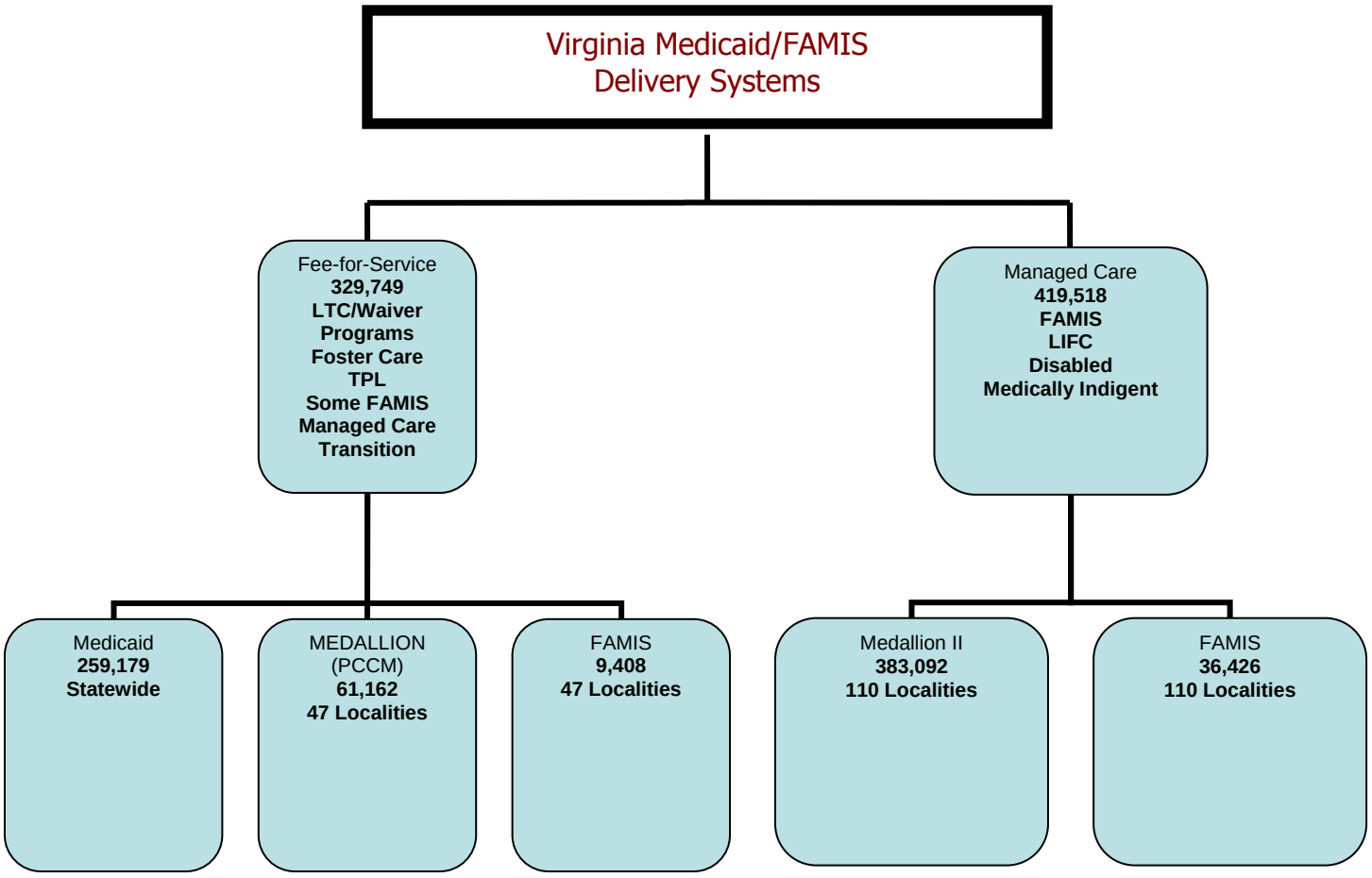
- **FAMIS** (Family Access to Medical Insurance Security Plan)
  - Title XXI-State Children's Health Insurance Plan (SCHIP)

2) Managed Care Organizations (MCO)

- **Medallion II**, a program utilizing contracted managed care organizations

- **FAMIS** (Family Access to Medical Insurance Security Plan)
  - Title XXI-State Children's Health Insurance Plan (SCHIP)

Note: Virginia has a combination Title XXI State Children's Health Insurance Plan (SCHIP) that consists of a separate FAMIS program and a Medicaid Expansion. SCHIP and Medicaid Expansion enrollment is reported under Medicaid FFS and Managed Care in the following chart.

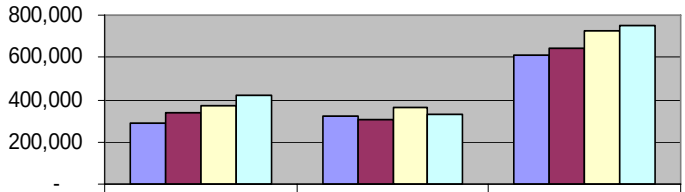


(Program enrollments and locality counts are as of June 2006)

The two delivery systems are structured to manage the ever-growing enrollee population. Figure 1 illustrates the growth of enrollees and expenditures per delivery system and includes enrollment and expenditures of the Family Access to Medical Insurance Security Plan (FAMIS), which is a Title XXI (SCHIP) program.

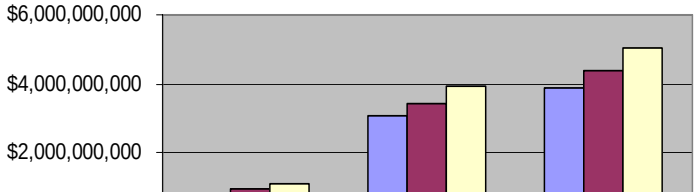
Figure 1. Enrollment and Expenditures

Enrollment



	Medallion II (Medicaid MCO)	MEDALLION/ Fee-for-Service	Total Enrollment
June 30, 2003	285,469	322,725	608,194
June 30, 2004	338,368	305,323	643,691
June 30, 2005	368,443	359,286	727,729
June 30, 2006	419,518	329,749	749,267

Expenditures

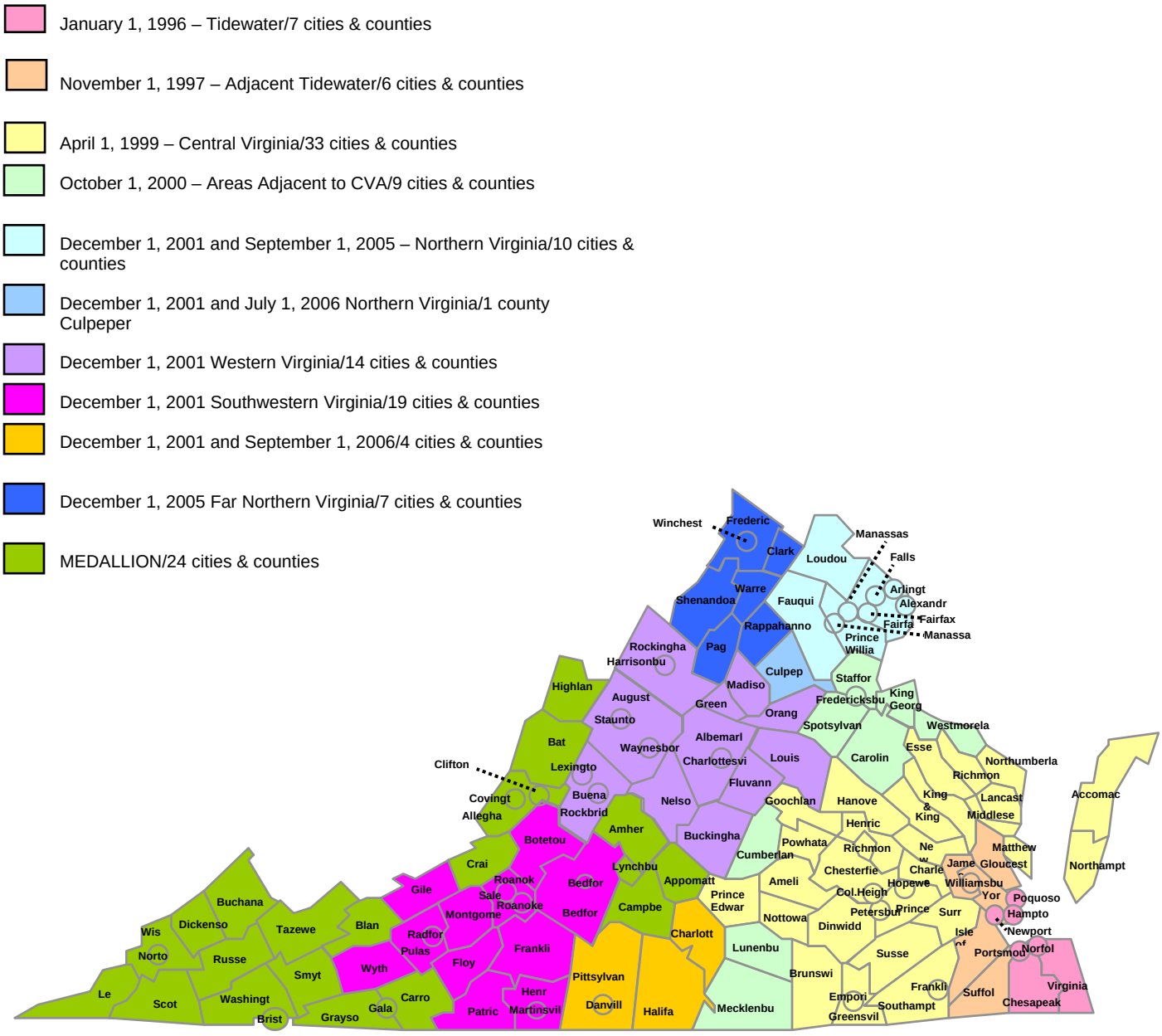


	Medallion II (Medicaid MCO)	MEDALLION/ Fee for Service (FFS)	Total Expenditures
June 30, 2004	$823,415,161	$3,072,051,605	$3,895,466,766
June 30, 2005	$967,573,476	$3,426,840,761	$4,394,414,237
June 30, 2006	$1,094,217,008	$3,932,763,716	$5,026,980,724

In regions where a managed care organization (MCO) is not available yet an enrollee is eligible for enrollment into a MCO, they are enrolled into MEDALLION, a primary care case management (PCCM) program. The MEDALLION program is fee-for-service unlike the Medallion II (MCO program) which is paid through a capitated agreement.

On December 1, 2005, Anthem HealthKeepers Plus, Optima Family Care and Virginia Premier began delivering services in the Winchester region. Effective July 1, 2006 AMERIGROUP Community Care began operations in Culpeper joining Virginia Premier as a MCO choice for Medicaid recipients. Figure 2 is a retrospective look at the growth of managed care operations throughout the Commonwealth.

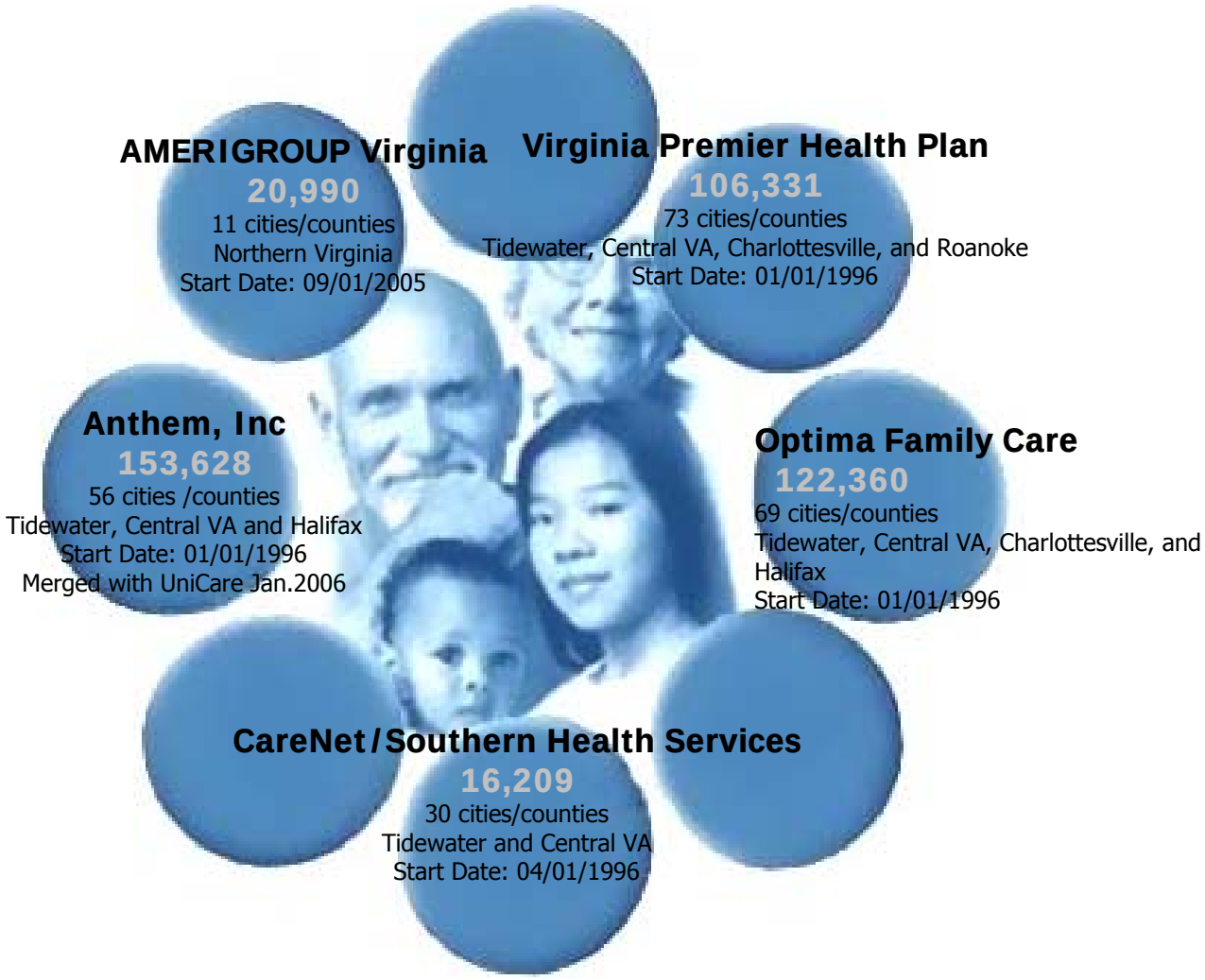
Figure 2. Managed Care Conversion Map



As depicted in the above map, Southwest Virginia, the most rural area of the state, does not have access to a managed care health plan. Based on outcomes, enhanced financial and health quality benefits are a result of services offered by managed care organizations. The Department will complete a procurement process to expand managed care operations into the Southwest region of the Commonwealth to benefit from these outcomes. The Department's mission is to provide a system of high quality and comprehensive health services and has chosen to offer managed care options to all eligible Medicaid enrollees throughout the Commonwealth to achieve this goal.

Health Plan Enrollment

Nationally, of the total Medicaid enrollment in the United States in 2004, approximately 60% of Medicaid enrollees are receiving Medicaid benefits through a managed care organization (MCO). Virginia mandates managed care enrollment through a section 1915(b) waiver of the Social Security Act for certain populations to enroll in an MCO. As of June 2006, Virginia has 56% (419,518) of its Medicaid population enrolled in one of five managed care organizations. This 56% represents 383,092 Medicaid and 36,426 FAMIS enrollees in 110 localities.



*Note: UniCare merged with Anthem/Wellpoint in January 2006.

MCO Enrollment

Enrollees as of June 2006

Localities, Regions, & Start Date

DMAS Mission: To provide a system of high quality, comprehensive health services to qualifying Virginians and their families.

Ensuring Quality Health Care

In an effort to ensure that each enrollee is receiving superior health care, the Department requires all health plans to obtain National Committee for Quality Assurance's (NCQA) accreditation. Anthem, CareNet and Optima are accredited and Virginia Premier and AMERIGROUP are actively seeking accreditation. Regardless of NCQA accreditation status, all plans are required to use NCQA's HEDIS measures.

The most prevalent source of MCO quality data is based on the NCQA's Health Plan Employer Data and Information Set (HEDIS®). HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to make informative decisions. Virginia Medicaid uses this information to effectively monitor health plans and ensure enrollees are receiving quality care using three benchmarks:

- Individual plan comparison to National HEDIS Medicaid averages
- Individual plan comparison to prior year outcomes
- Aggregate/Medallion II program comparison to Fee for Service (MEDALLION and Title XIX-Standard Medicaid) outcomes, where applicable

The Department requires all MCOs to report audited rates on selected HEDIS measures. Additionally, each MCO was required to develop and implement defined disease management programs no later than November 1, 2006 with a special focus on pediatric asthma and pediatric diabetes programs.

The following pages exhibit HEDIS data outcomes that illustrate areas where the Virginia Medicaid MCOs' diligent efforts have resulted in improved health quality for enrollees and opportunities for improvement in the areas of chronic and preventative care.

****NATIONAL ATTENTION****

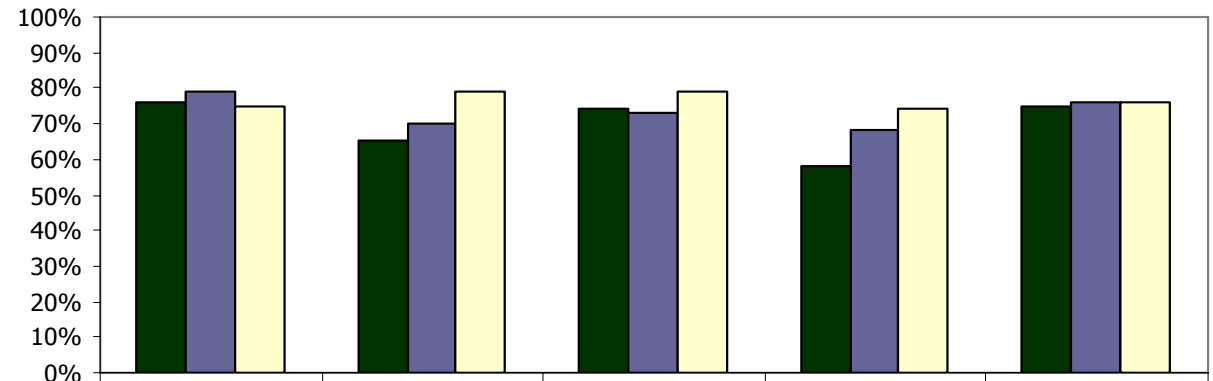
- **4 of the 5 Virginia Medicaid MCOs** (Anthem, Optima, CareNet and Virginia Premier) **were ranked in 'America's Best Health Plans' by U.S. News and World Report**. More than 680 plans were assessed for quality of care and the Top 50 commercial and 25 Medicare and Medicaid plans are highlighted in the magazine.
- Optima Family Care, Anthem Healthkeepers Plus, Anthem Peninsula Health Care, Anthem Priority Health Care and Southern Health/CareNet received an **'Excellent'** accreditation status from the National Committee for Quality Assurance.
- The Center for Health Care Strategies (CHCS) awarded DMAS and Virginia Premier Health Plan, Inc. the Innovation Award *for Improving Health Care Quality for Racially and Ethnically Diverse Populations.* The innovation award was given to reduce racial and ethnic disparities among postpartum Medicaid members. The goal of the program is to increase the numbers and length of time that African American women breastfeed their infants.
- The home-based Sickle Cell treatment program pioneered by a collaborative including the Eastern Virginia Medical School, Sentara Home Care Services, Sentara hospitals and Optima Health has won a national award from the Disease Management Association of America (DMAA) for preventing Sickle Cell crises and sharply reducing emergency department visits and hospitalizations.

Managed Care Disease Management

Diabetes: According to the American Diabetes Association, there are 20.8 million children and adults in the United States, or 7% of the population, who have diabetes. On average, 2% of enrollees, per DMAS managed care organizations, are diabetic. The health plans have worked to increase the efficiency of diabetic disease monitoring through outcomes in glucose (HbA1c testing) and cholesterol screenings. Two MCOs' 2006 rates are slightly below the HEDIS benchmark (76%) on A1c testing and all but one of the health plans meet the national Medicaid LDL-C screening rate (81%).

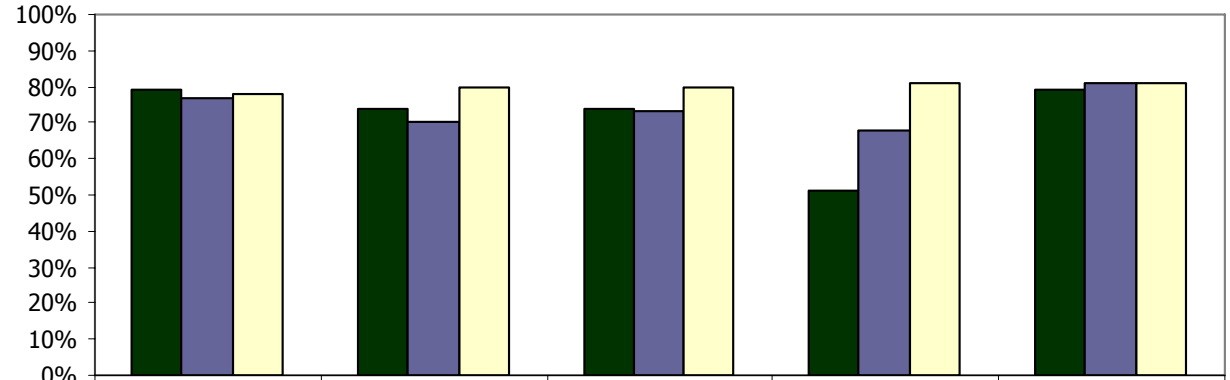
However, on average, most plans have improved rates in both areas (12% and 14%, HbA1c and LDL-C, respectively) in the last three years.

Figure 3. Comprehensive Diabetes Care: Rating of A1c Testing
Source: NCQA HEDIS 2004-2006 Data Submission Tool



	Anthem	CareNet	Optima	VA Premier	HEDIS National Medicaid Average
2004	76%	65%	74%	58%	75%
2005	79%	70%	73%	68%	76%
2006	75%	79%	79%	74%	76%

Figure 4. Comprehensive Diabetes Care: Rating of LDL-C Level Screening
Source: NCQA HEDIS 2004-2006 Data Submission Tool

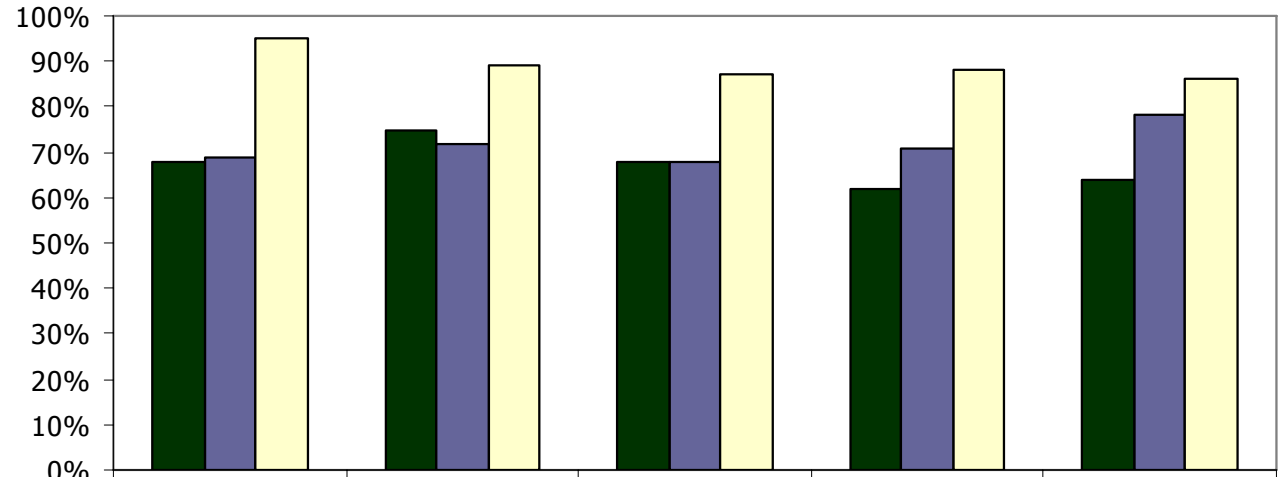


	Anthem	CareNet	Optima	VA Premier	HEDIS National Medicaid Average
2004	79%	74%	74%	51%	79%
2005	77%	70%	73%	68%	81%
2006	78%	80%	80%	81%	81%

Asthma: In the 2006 *Trends in Asthma Morbidity and Mortality* study conducted by the American Lung Association, asthma is cited as one of the top ten health conditions in the nation. Currently, DMAS MCOs report that a combined 35,888 (average of 9% per MCO) of their enrollees have been diagnosed with asthma. However, successful intervention efforts to reduce this burden have resulted in reduced mortality and hospitalization from asthma attacks. Since 2004, the rates for the HEDIS measure 'use of appropriate asthma medications' had improved significantly for each MCO; the rates for all plans (87%-95%) are above the national HEDIS average (86%).

Interventions such as creating new disease management units, hiring nurse case managers and disseminating educational materials have proven successful for all plans over the last three measurement cycles.

Figure 5. Use of Appropriate Asthma Medications
Source: NCQA HEDIS 2004-2006 Data Submission Tool



	Anthem	CareNet	Optima	VA Premier	HEDIS National Medicaid Average
2004	68%	75%	68%	62%	64%
2005	69%	72%	68%	71%	78%
2006	95%	89%	87%	88%	86%

Fee for Service Disease Management Program: *Healthy Returns*

The 2005 Virginia General Assembly approved funding for a Disease State Management (DM) Program and on January 13, 2006, after a successful piloted program, Virginia Medicaid implemented the Healthy Returns[SM] Disease State Management (DM) Program. DMAS has contracted with Health Management Corporation (HMC) to administer the program. In Virginia, Healthy Returns[SM] is a program designed to help patients better understand and manage:

- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Asthma
- Diabetes

The strategies used are prevention, education, lifestyle changes, and adherence to prescribed plans of care (POC). Healthy Returns[SM] is currently an "opt-in" program and as of August 31, 2006, 16,000 (99.7%) of all those identified as eligible for the program agreed to participate. Eligibility for the program includes fee-for-service enrollees with the exception of those who are enrolled in Medicare (dual eligibles), those who live in an institutional setting such as nursing facilities, and those who have third party insurance.

Results from the piloted program show that members with chronic conditions improved their health status and adherence to guidelines and, in addition, there was an optimized utilization of services. As utilization patterns change in a positive manner, costs are more effectively controlled. This is illustrated by:

- Expense per diagnosed member per month (PDMPM) decreased $23 between Baseline and Year 1 (from $1248 to $1225), leading to a 2% gross savings rate.
- The overall savings was driven by a decline in pharmacy expense ($17 PDMPM) as total medical expense decreased $6 PDMPM, driven by non-condition-related expenses. While overall results are positive and improvements were made, the fact that non-condition-related expenses drove the savings indicates there is much room for improvement to successfully manage these conditions.
- Across all settings, there were improvements in expense for diagnoses related to program managed conditions:
    - For other forms of heart disease, there was a 9% decline PDMPM expense.
    - Expense related to hypertensive disease declined 15%.

In summary, program results indicate that the Healthy Returns Disease Management Program is making strides in improving the health of DMAS enrollees in the pilot program. As the pilot program expands to include members with asthma, diabetes and chronic obstructive pulmonary disorder (i.e., the current program), enrollees will continue to experience improved outcomes and health status. Next year, the Department will benchmark several measures from Healthy Returns[SM] with health plan outcomes.

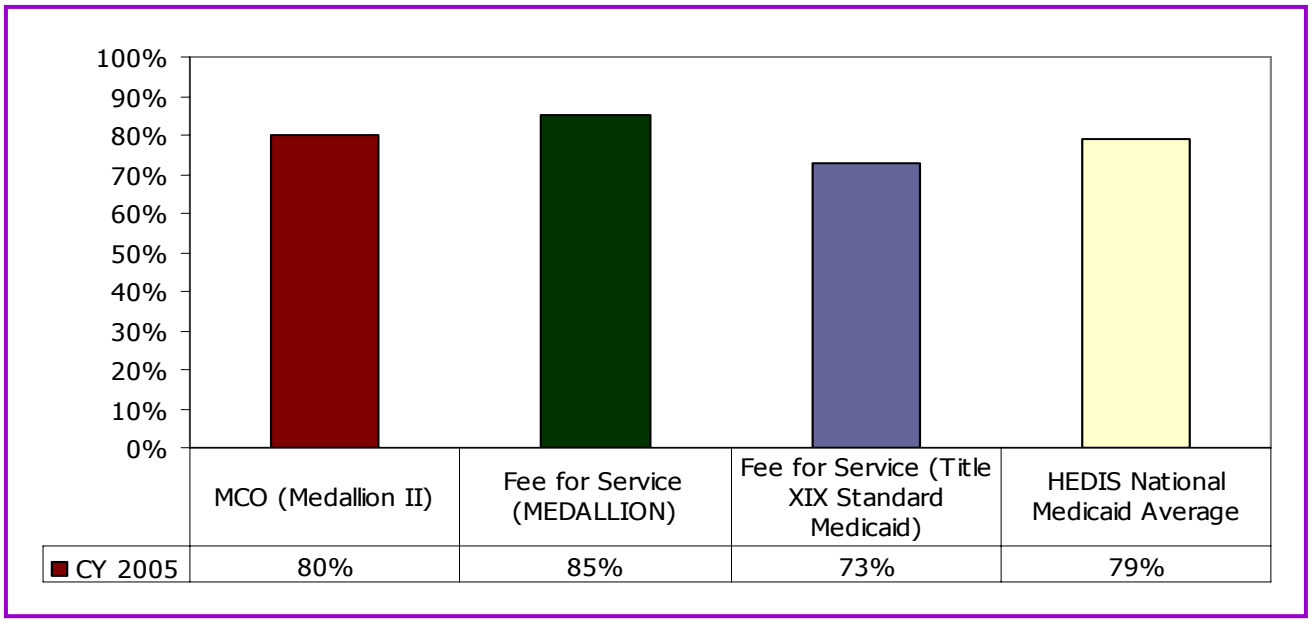
For more information on the DM program, go to: http://www.dmas.virginia.gov/dsm.htm.

Preventative Care

While the prior section illustrated outcomes in disease management, quality of care also focuses on prevention. Prenatal care, immunization status, and well child visits are three areas of preventative care monitored by DMAS.

Obstetrical Care Outcomes-Prenatal Care Timeliness: According to Maternal and Child health data, there were 45,911 (36,695 in FFS and 21,486 in a MCO) Medicaid pregnancies in calendar year 2005. The HEDIS definition for timeliness of prenatal care is as follows: the percentage of women enrolled in an MCO that received a prenatal care visit during the first trimester within 42 days of enrollment. It is important to note, enrollees may not have been assigned to an MCO until six weeks after enrollment in Medicaid. Despite barriers to early enrollment (thus earlier prenatal care), individual MCO and Medallion II rates exceed/remain comparable to the national Medicaid rate.

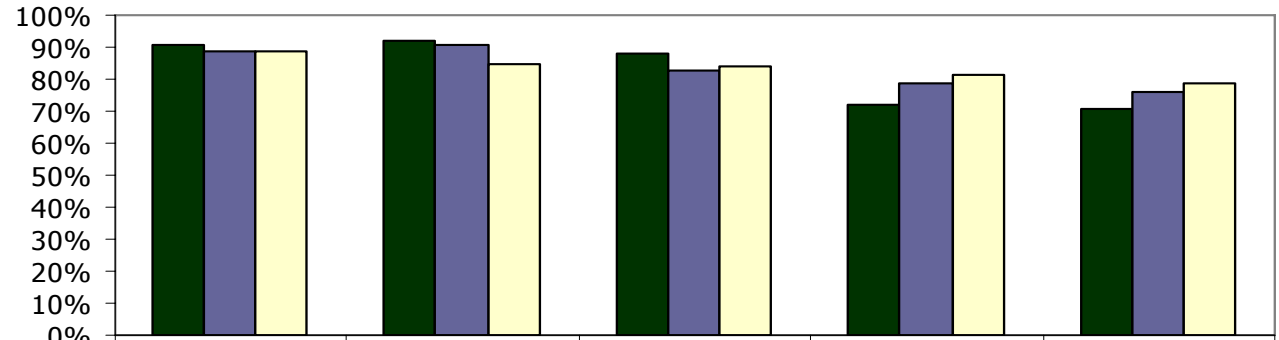
Figure 6. Prenatal Care Timeliness by Delivery System*
(Source: Prenatal Care Study – CY2005)



	MCO (Medallion II)	Fee for Service (MEDALLION)	Fee for Service (Title XIX Standard Medicaid)	HEDIS National Medicaid Average
CY 2005	80%	85%	73%	79%

*Rates are comparable across Virginia Medicaid program delivery systems.

Figure 7. Prenatal Care Timeliness by MCO
(Source: NCQA HEDIS Data Submission Tool 2004-2006)

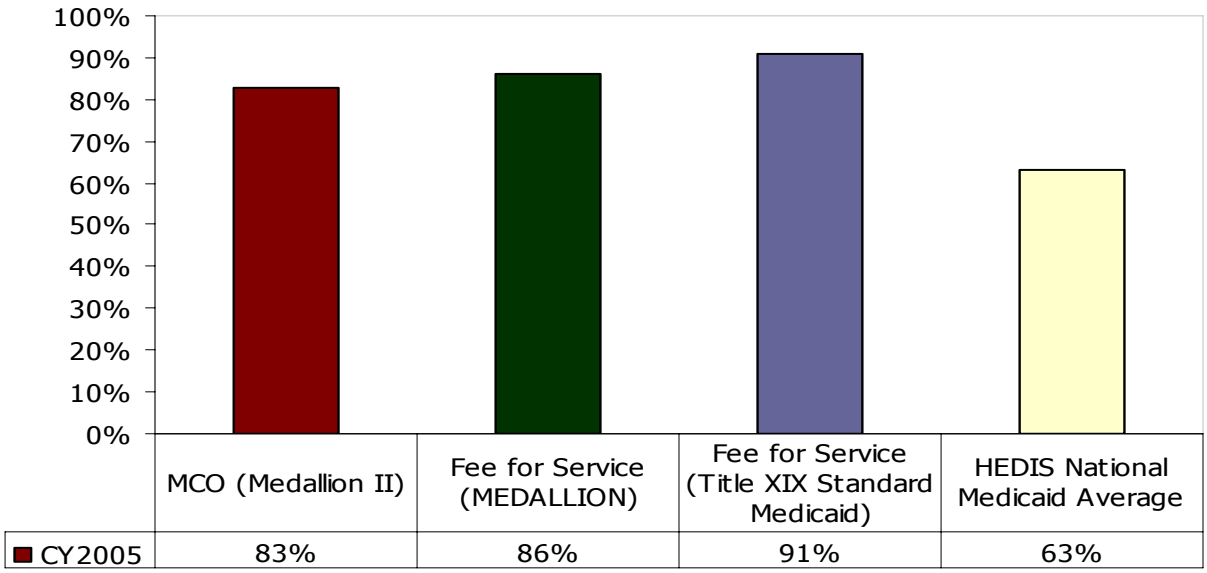


	Anthem	CareNet	Optima	VA Premier	HEDIS National Medicaid Average
2004	91%	92%	88%	72%	71%
2005	89%	91%	83%	79%	76%
2006	89%	85%	84%	81%	79%

Immunizations: According to a 2006 report by NCQA, across the country people enrolled in Medicaid plans benefited from a sharp increase in childhood immunizations. MCO improvements in this area are exemplary; enhanced data collection and outreach efforts have resulted in rate increases from 8-11%.

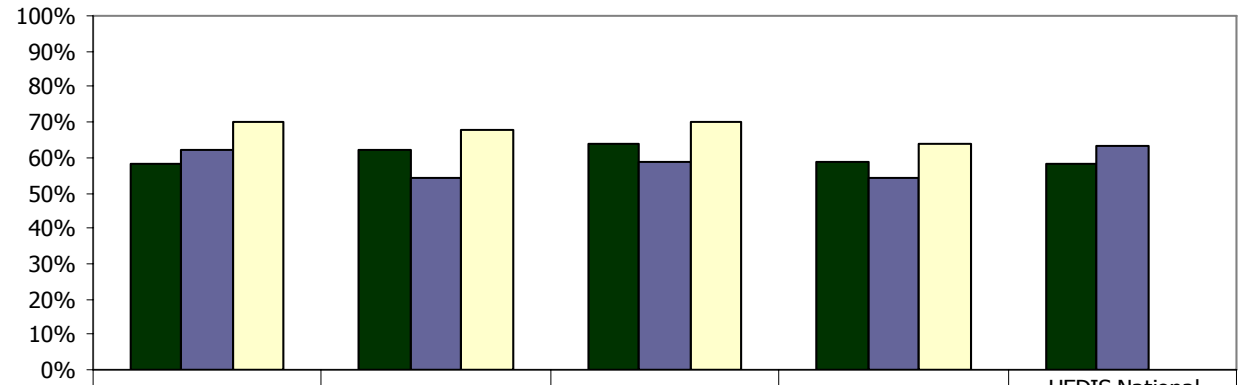
NCQA has retired the HEDIS measure for Combination 1 (4 DTP/3 polio/1 MMR). The Virginia Medicaid rate for Combination Two (83%) has exceeded the national Medicaid average of 62.87%. It is imperative to note, on average, MCOs have increased scores 7% from 2004 to 2006. According to HEDIS guidelines, +/-5% difference in rate indicates a noteworthy change.

Figure 8. Childhood Immunizations-Combo Two (4 DTP/ 3 IPV/ 1 MMR/ 3 Hib/ 3 HBV/ 1 VZV) by Delivery System
(Source: Immunization Study at 24-Months – CY 2005)*



*Rates are comparable across Virginia Medicaid program delivery systems.

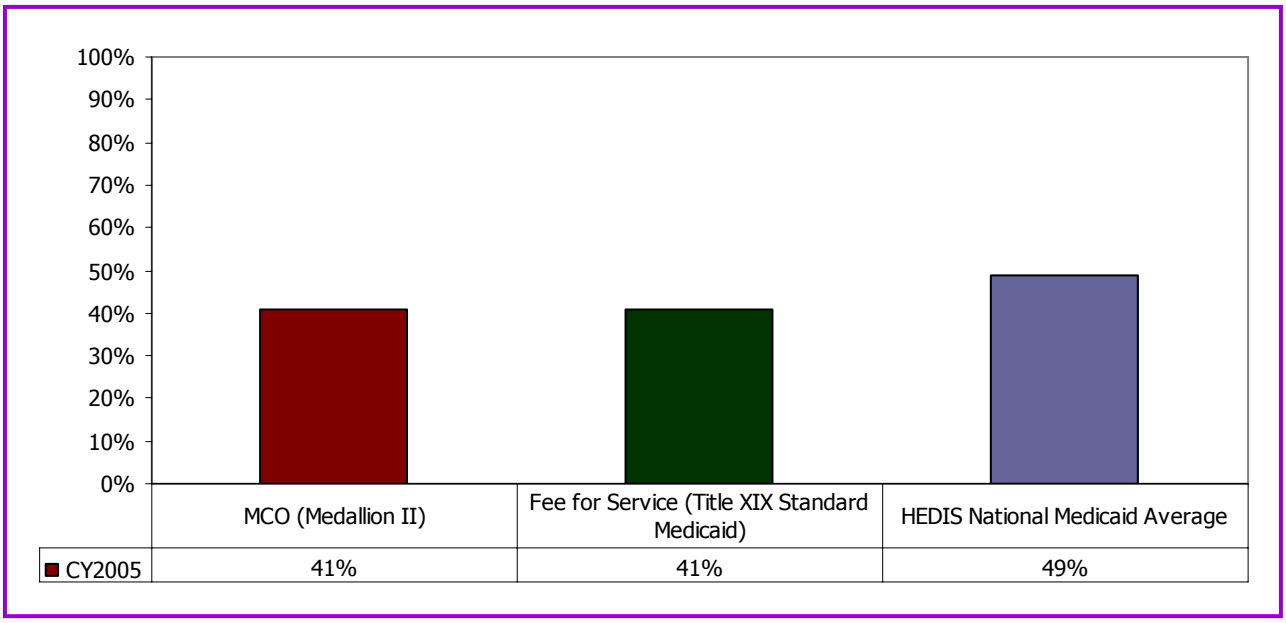
Figure 9. Childhood Immunizations-Combo One (DTaP, OPV/IPV, MMR, Hib, Hep B) by MCO
(Source: NCQA HEDIS Data Submission Tool 2004-2006)



Well Child Visits: The Department monitors the frequency of well child visits conducted by MCOs based on American Academy of Pediatrics guidelines. These guidelines recommend that a child should receive at least seven well child visits by 15 months and the corresponding HEDIS measure captures data for recipients with six or more visits. Despite these improvements, the aggregate data for the CY2005 well child rate indicate the need for additional efforts in this area.* Additionally, the Department is closely monitoring well child rate improvements as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

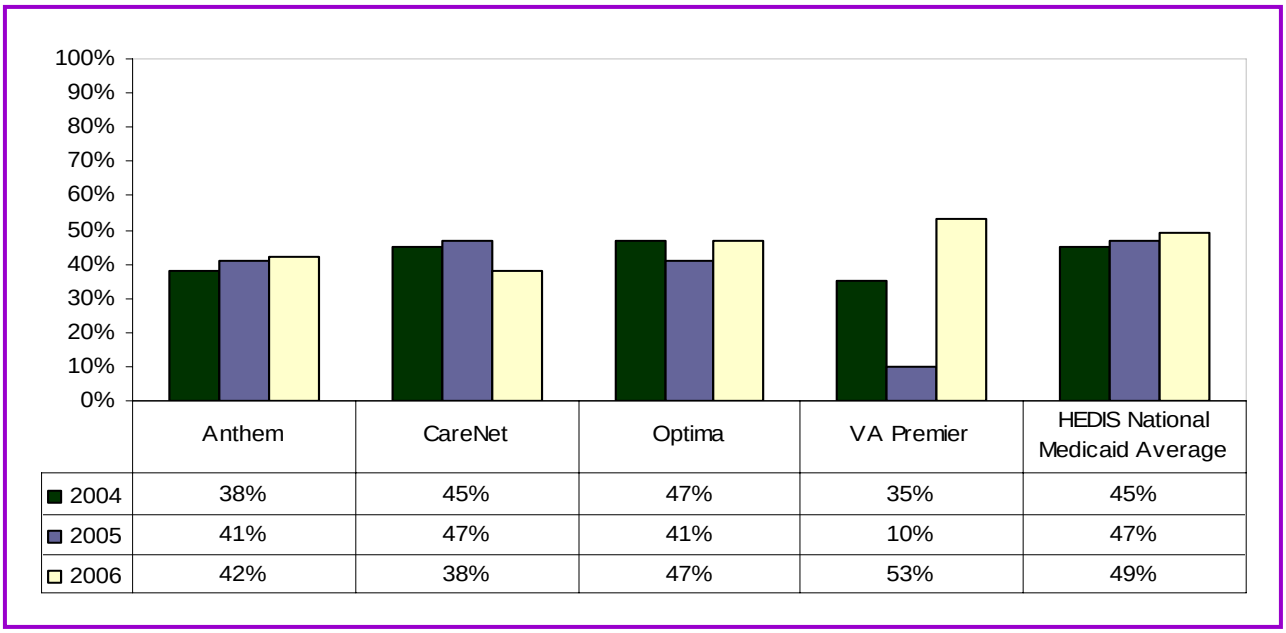
However, all MCOs except one experienced an increase in their HEDIS rates resulting in an average MCO increase of 10%. MCO rates increased significantly due to partnerships with schools, in-house data collection and utilization of the hybrid methodology (administrative claims and chart review) with use of new electronic (previously manual) systems.

Figure 10. Well Child Visits at 15 months of Life -6 or more Visits by Delivery System (Source: FAMIS Well Child Study- CY2005)



Note: As the delivery system had insufficient numbers for analysis according to NCQA specifications, data were not calculated for

Figure 11. Well Child Visits at 15 months of Life -6 or more Visits by MCO (Source: NCQA HEDIS Data Submission Tool 2004-2006)



**** STATEWIDE ATTENTION****

Based on the increased focus on outcomes, the MCOs are now collaborating on two mandatory performance improvement projects to improve their two lowest HEDIS rates; Childhood Immunizations and Well Child Visits at 15 months. To date, three meetings have been held with the MCOs Quality Improvement teams along with representatives from the Virginia Medical Society, Virginia Association of Health Plans, American Academy of Pediatrics and the Virginia Department of Health. The collaborative is developing educational materials to assist medical office staff in the proper coding of well child visits and to identify immunization opportunities.

This important initiative was highlighted in the Virginia Chapter of the American Academy of Pediatrics Fall 2006 newsletter.

Current and Future Quality Initiatives

Focused Studies: The Department is currently conducting an in-depth utilization analysis of MCO services with a focus on children with special healthcare needs.

Performance Levels: As of SFY 2007, MCOs are required to submit a corrective action plan based on the following:

- The MCO fails to meet the national benchmark or decreases their previous year's HEDIS rate by 5%
- The MCO receives a status of 'partially met' or 'unmet' on operational systems review elements or performance improvement project requirements

The MCO will be evaluated on successful implementation of such corrections in the plan's annual external quality review the following year.

Disease Management: By July 1, 2007, all MCOs must develop and implement a defined disease management program that focuses on improving the health status of children identified as obese.

Next year, quality studies will focus on FFS and MCO benchmarks in several measures.

Scientists and healthcare professionals agree that Americans need to embrace healthier lifestyles, or the costs to our quality of life and our health care system will be devastating. The Department has concentrated efforts in the areas of Medicaid Reform, Integration of Acute and Long-Term Care, and Pregnant Women.

Medicaid Reform - *Medicaid Revitalization Committee*

House Bill 758, passed by the 2006 Virginia General Assembly and signed by Governor Kaine on April 5, 2006, set into motion a review of Medicaid. The legislation created the Medicaid Revitalization Committee (MRC) consisting of patient advocates, healthcare providers, and other stakeholders. The Committee examined alternatives and innovative approaches to healthcare delivery under Medicaid. The focus was on:

- Client-centered planning,
- Individual budgeting, and
- Self-directed quality assurance and improvement.

The committee met five times in a public forum setting. As a result of the meetings, a report will be submitted to the Office of the Governor, the House Committees on Appropriations and Health, Welfare and Institutions, and the Senate Committees on Finance and Education and Health that will include recommendations from the MRC focused on Disease Management, Enhanced Benefit Accounts, Electronic Access to Virginia Medicaid, Medicaid Managed Care, and Employer-Sponsored Insurance Subsidies and Buy-In Programs. The final report is available at http://www.dmas.virginia.gov/downloads/pdfs/ab-mrc-Draft_Rpt_10_20_06.pdf.

Integration of Acute and Long-term Care - *Blueprint*

In an address to the Commonwealth, Governor Kaine directed DMAS to develop a plan which will serve as the ***blueprint*** for moving towards an integrated, acute and long-term care delivery system for elderly and disabled Medicaid recipients. This plan will enable the Department to develop a system that is based on providing coordinated (case management) care to recipients. This directive involves two models for the integration of acute and long term care services: a Community Model and a Regional Model.

The Community Model is one that is locally developed with an area agency on aging and a health care system (such as a PACE site). A PACE site (Program of All Inclusive Care for the Elderly), which serves persons 55 and older that meet nursing facility criteria in the community, provides all health and long term care services centered around an adult day health care model, and combines Medicaid and Medicare funding. In order to move to the next step of implementation, Governor Kaine amended the budget and awarded $1.5 million in start up funds to the Department.

A Regional Model could range from a capitated payment system (Medicaid or Medicaid/Medicare) for acute care costs only and care coordination services for the home and community based services, to a fully capitated system for all acute and long term care services.

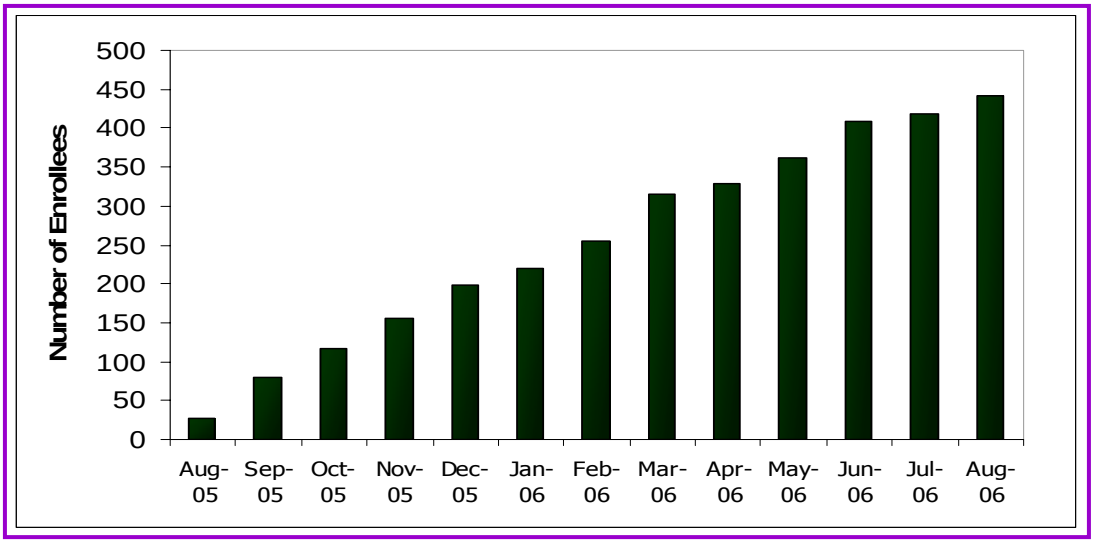
Three meetings were held to assist in the development of the Integration of Acute and Long-term Care blueprint. The recommendations of going forward with the integration of acute and long-term care services will be submitted in a report to the Virginia General Assembly on December 15, 2006. For more information on the Blueprint: (http://www.dmas.virginia.gov/altc-home.htm)

Pregnant Women - *FAMIS MOMS*

Medicaid covers pregnant women below 133% of the Federal Poverty Limit (FPL), thus leaving a portion of mothers without adequate health insurance to cover prenatal care. In an attempt to close this gap, FAMIS MOMS was implemented on August 1, 2005. This program is offered to women who fall between 133% -166% of the FPL. The target enrollment was 380 women for the first year yet the program has exceeded this estimate; as of August 2006, 680 had been covered in the program.

One challenge faced by the FAMIS MOMS program is the need for immediate medical insurance for the newborn child. Because automatic enrollment of the newborn is not allowed, a parent had to apply for FAMIS benefits during the birth month to receive coverage for the birth-related medical expenses. To address this problem, as of September 1, 2006, retroactive FAMIS coverage consideration is given for newborn children only. When the applicant requests retroactive coverage, children (including the children of FAMIS MOMS) who were born within the three months prior to the month the signed application is received may be eligible for coverage back to their date of birth if they meet all the eligibility requirements in the retroactive period.

Figure 12. FAMIS MOMS Monthly Enrollment
(Source: Division of Maternal and Child Health 2005 Annual Report)



FAMIS MOMS
Covering Pregnant Women With Affordable Health Insurance

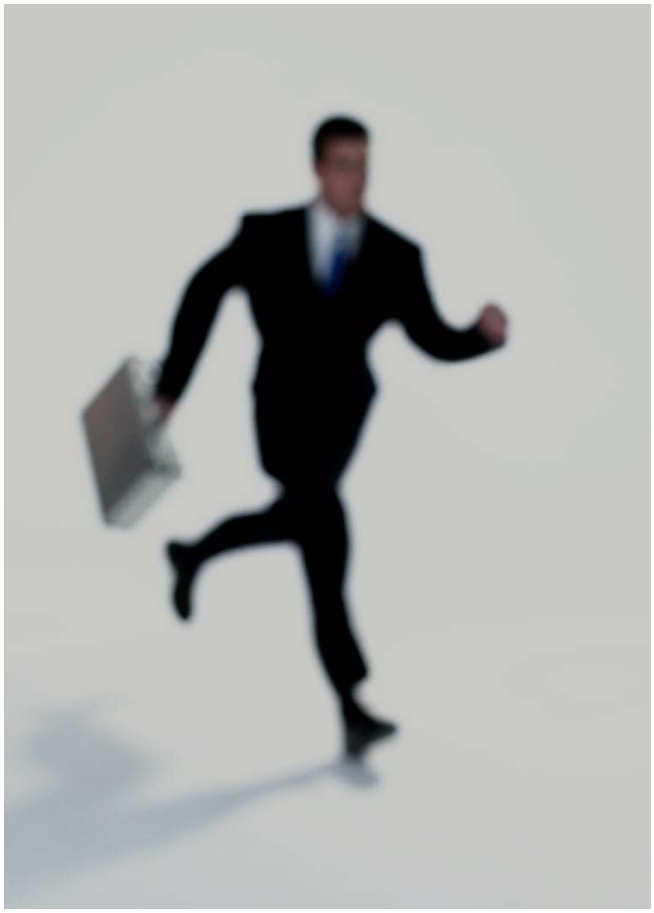
For more information on FAMIS programs: www.famis.org

Summary

The problems are clear…

There is a need for initiatives to encourage preventative health and the use of best practices within budgetary constraints. The surge in the aging population, issues of access to healthcare for the uninsured and quality improvement efforts present major challenges.

Virginia Medicaid, along with the Governor's office, is committed to developing and implementing those services required to meet the critical healthcare needs of Virginia Medicaid enrollees.



MANAGED CARE CONTACTS

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